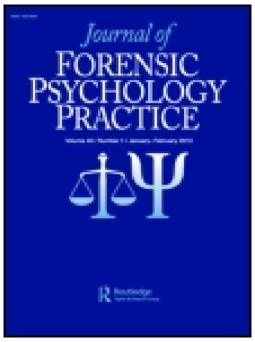

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CASE REPORT

Towards an Evidence-Based Clinical Forensic Diagnostic Assessment Framework for Juvenile Fire Setting and Bomb Making: DSM-5 Quadrant

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Juvenile fire setting and bomb making (JFSB) poses clinical, cross-disciplinary, ethical, and legal challenges. For example, the discipline lacks an available assessment method that is specifically designed to guide the diagnostic work with JFSBs. Consistent with the Diagnostic and Statistical Manual of Mental Disorders *(5th edition; DSM-5), an expanded dimensional diagnostic framework referred to as the DSM-5 Quadrant is recommended as a valid approach to augment the clinical utility for both case conceptualization and crafting forensically relevant interventions aimed at these youth. This article identifies issues associated with assessing mental health symptoms frequently found within the JFSB population.*

KEYWORDS DSM-5, juvenile fire setting, DSM-5 Quadrant, forensic psychology

Only a paucity of forensic psychological research is exclusively focused on the range of diagnostic factors confronted while working with juvenile fire setting and bomb making (JFSB). Consistent with the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition; DSM-5), the JFSB risk profile points to mental health functions as a major contributing variable, probably best assessed across several disorders (APA, 2013). Nevertheless,

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the research is complicated since most youth in the correctional system for fire setting do not collectively meet the criteria for the ones most commonly represented in DSM-5 (Johnson, Beckenbach, & Killbourne, 2013), although the rates for JFSB compared to non-JFSB are disproportionately higher for antisocial personality disorder in forensics cases (Vaughan et al., 2010). For example, fire setters with mental illness are more likely than fire setters without mental illness to have prior convictions for fire setting (Jayaraman & Frazer, 2006; Koson & Dvoskin, 1982). Alcoholism and substance use are also found in this JFSB group (Enayati, Grann, Lubbe, & Fazel, 2008; Grant & Kim, 2007; Labree, Nijman, Van Marle, & Rassin, 2010; Ritchie & Huff, 1999)

The underlying public safety issues stemming from JFSB cases can be more high-profile (e.g., joint responses from the fire service and police) than other offenses. The inexperienced examiner in these cases can fuel increased malpractice risks that arise from missed diagnoses, misdiagnoses, or overdiagnoses in JFSB cases. For example, an inappropriate diagnosis or inaccurate risk assessment can compromise interventions aimed at risk reduction. In addition, an inaccurate JFSB diagnosis or risk assessment can also result in unwanted public safety consequences and psychological harm. Harm can be defined as a loss stemming from diagnostic errors, poor evaluations, and other forensic work miscues. These types of harm are all potential sources for malpractice litigation (Berman, 1989; Conte & Karasu, 1990; Jobes & Berman, 1993; Pope, 1986, 1989; Roswell, 1988; Shapiro, 1987; Wilbert & Fulero, 1988; Wright, 1981). One suggested option to mitigate this harm is to offer for consideration a more targeted cluster of co-occurring disorders that captures many of the commonly occurring clinical symptoms often found in JSFB. The DSM-5 Quadrant refers to a diagnostic assessment framework that can be applied to the diverse symptoms (e.g., attention deficit hyperactivity disorder [ADHD], conduct disorder [CD], autism spectrum disorder [ASD], posttraumatic stress disorder [PTSD]) presented by JFSB (Johnson, 2014). While discussed more in detail later in this article, the DSM-5 Quadrant is structured in a way that offsets some examiner's factors (e.g., competency) in these cases, and may prompt them to reflexively apply diagnostic assessment tools in a way (i.e., noncomorbid) that does not effectively distinguish between several conditions that are potentially present in a JFSB. Diagnostically, comorbidity among JFSB children represents an important clinical forensic issue, as JFSB is often associated with an expanded symptom severity pattern that is addressed by using the DSM-5 Quadrant.

Similar to other forensic psychology areas, the full appreciation for public safety threats alone buttresses the need to choose a diagnostic approach that relies on a decision guide that reinforces desirable practices within a forensic psychological evaluation. The diagnostic guide (DSM-5 Quadrant) is also expected to help reduce costs and assist with the crafting of culturally responsive therapeutic enhancement activities (TEAS) with JFSBs (Johnson, Young, Fessler, Collins, & Wilson, 2014; Rees, 2006). For example, from

2007 to 2011, there were 5,690 reported fires on educational property annually (Campbell, 2013). From an international perspective, JFSB constitutes an expensive, life-threatening problem for society and victims that is caused by youth under the age of 19 (Kolko, 2012; Kolko, Day, Bridge, & Kazdin, 2001; Lowenstein, 2001). For example, Campbell (2013) reported $92 million in direct property damage. These threats can range from playing with matches, lighters, or portable torches, to setting fires. JFSB incidents can take place in community, fields, home, residential facilities, schools, or trash dumpsters. All of the materials needed for setting fires are readily available to juveniles. The aforementioned public safety threats underscore the need for increased awareness of the importance that diagnosis plays with JFSBs, particularly for cross-disciplinary professionals (e.g., attorneys, school personnel, law enforcement, mental health counselors, fire service personnel, psychologists, and social workers) who rely upon it.

In terms of JFSB prevalence, juveniles account for 54% of all arson arrests in the United States, according to a 2005 report from the Office of Juvenile Justice and Delinquency Prevention (Putnam & Kirkpatrick, 2005). As noted on a juvenile fire prevention Internet site: “Arson is the only crime tracked by the FBI for which more juveniles are arrested than adults” (Fireproof Children [FC], 2010). Juveniles in these incidents range in age from 3 to 19 (Barreto, Boekamp, Armstrong, & Gillen, 2004; Hanson, Mackay, Atkinson, & Staley, 1995; Pollinger, Samuels, & Stadolnik, 2005). A recent statistical analysis of 1,698 referred cases of juvenile arson in San Diego County shows 32.4% of these cases were children of age 10 or younger. Of these children, 39.2% were in grades 1 through 6, with 4.5% in preschool or kindergarten. Around 31% of all juvenile arson cases in this referral group took place on school grounds, at bus stops, or in school buses (Johnson, Jones, & Said, 2013).

These numbers are extremely alarming when viewed in light of the known and estimated costs in human life and property damage caused by the arson. A 2012 United States Federal Emergency Management Agency (FEMA, 2012) report, which only accounts for the federally reported and tracked incidents, indicated that between 2005 and 2009 there were, on average, 56,300 child-playing fires (meeting the willful requirement for the federal definition of arson) reported to U.S. municipal fire departments per year. These incidents caused, on an annual average, 110 civilian deaths, 880 civilian injuries, and $286 million in property damage. Structure fires, which accounted for 22% of all the fires tabulated, were associated with 98% of civilian deaths by fire, and 93% of the property damage (FEMA, 2012). Internationally, JFSBs comprise roughly one-third of all bombs made by people younger than 19 (Faranda, Lim, Katsikas, & Fegley, 2005). The U.S. Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) investigated 13,510 cases between 1993 and 1997 of actual and attempted explosive incidents involving juveniles. The prevalence of JFSB points to the relevance of having an accurate diagnosis.

A missed diagnosis in a JFSB case typically involves acts of omission (e.g., failure to properly account for other possible mental health disorders). There are also acts of commission or misdiagnosis (e.g., making a clinical forensic diagnostic decision based on myths about JFSBs). For example, inaccuracies in the work practices of an examiner are determined largely by what they do or fail to do during the diagnostic data collection process. A common problem is an examiner who confuses the relative absence of clinical elevations on testing results as a significant justification for them to render a "low-risk" assessment rating for a JFSB case. It is essential to note that examiners bear considerable responsibility for missed opportunities for making an appropriate diagnosis with JFSBs. In this case, an examiner must work to gather a set of symptoms that are specifically relevant to the diagnosis (Brodsky & Cramer, 2008; Wilbert & Fulero, 1988).

The symptoms observed in JFSBs frequently follow a variable clinical course that may mimic several mental disorders (Johnson et al., 2013; Johnson & Jones, 2014). When these symptom-factors are combined with an inexperienced service provider, they often lead to a challenging diagnostic process. For example, a JFSB ASD patient's difficulties in social skills can mimic symptoms associated with a thought disorder. In addition, JFSB diagnoses can be plagued by lingering mental health myths (e.g., fire setters have enuresis or abuse small animals) or by the mistaken impression that a forensic psychological examiner must come up with *one* definitive DSM-5 diagnosis for this clinical forensic population (Duff & Kinderman, 2008; Hopwood & Sellbom, 2013). It is also a myth that all JFSB meet the criteria for pyromania.

Like its predecessors, the DSM-5 is expected to be the most widely used diagnostic reference tool for JFSB (Johnson et al., 2013). Yet, after being released for over one year, there are mental health professionals who are not using the current manual or who continue to utilize the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; DSM-IV-TR). Additionally, some mental health counselors mistakenly believe that an option in the American Counseling Association's ethical code to not render a diagnosis will somehow exempt them from malpractice risks or litigation stemming from such practice (American Counseling Association [ACA], 2014). To little surprise, over multiple versions, the DSM has received considerable criticism for various reasons. One criticism is that the DSM utilizes a categorical approach. The National Institute of Mental Health (NIMH) elected not to fund research that included use of the DSM-5 as part of any investigation (Grant et al., 2005; Oldham et al., 1992; Zimmerman et al., 2012). Other criticisms center on questions about the appropriateness of relying upon a categorical approach while working with forensic cases such as JFSBs. Young

(2013) reports that DSM-5 conceptualizations should take into account models that address the overlapping nature of disorders. According to Young (2013), “A psychiatric diagnostic manual needs to evidence both clinical utility and scientific validity. It needs to be both useful in practice and based on valid empirical findings and conceptualization” (p. 346).

There is heterogeneity among JFSB patients receiving the same DSM-5 diagnoses. As such, it is probably unwise to establish a fixed diagnostic threshold that may not fully capture a more accurate assessment picture (Balsis, Lowmaster, Cooper, & Benge, 2011). In this case, individuals predictably have many behavioral characteristics, but not all symptoms are the same across all patients (Hyman, 2010; Morey et al., 2007, 2012). Over many decades, there has been an ongoing debate around whether or not psychological factors should be identified as discrete or continuous; however, there are benefits documented in the literature on the use of a categorical-dimensional hybrid (Krueger, Skodol, Livesley, Shrout, & Huang, 2007; McGlashan et al., 2005). A proposed alternative to be presented later represents a substantial departure from the strictly categorical approach, for it is diagnostically more informative when used with forensic cases like JFSB. It offers valid information that is absent with discretization.

There are four advantages to using a more expanded diagnostic framework for JFSB. First, historically, diagnostic systems such as the DSM-5 and ICD-10 were partly crafted in order to facilitate better communication between all the relevant stakeholders involved in clinical forensic work (Johnson, 2013a, 2013b). Second, an expanded framework promotes mutual understanding and rectifies miscommunications with the JFSB patient and family. Third, this expanded diagnostic framework can help assist with culturally responsive interventions circumscribed to JFSB in a fashion that parallels other DSM-5 guides (e.g., Section III’s cultural formulation and Glossary of Cultural Concepts of Distress; APA, 2013). Finally, written intervention plans (e.g., therapeutic enhancement activities or TEAS) have the potential to be evidence-based and inclusive of the various diagnostical issues that could impact its implementation.

However, even an expanded diagnostic system cannot be a flawless tool; there are at least three disadvantages for such a system. First, for a novice examiner, exclusively relying on a framework like the DSM-5 Quadrant can contribute to overlooking other potentially relevant diagnostic JFSB information (Gordon & Cosgrove, 2013; Johnson, 2014). The diagnostic framework used in a decision-making template is more or less circumscribed to disorders that theoretically reflect the biases of the author. In other words, it is plausible that an expanded diagnostic view of the JFSB does not preclude the possibility that mental disorders can occur outside the frame of the expanded diagnostic scaffolding recommended here. In this case, a JFSB diagnosis does not supersede the primacy or priority of public safety (Gutman & Sadoff, 2014; Jorm, Reavley, & Ross, 2012). Finally, it may be that the diagnostic problems are obscured in some way by a function of the setting (e.g., fire services, school, inpatient unit, private therapist, social service agency, or community-based mental health) in which a JFSB patient is encountered.

In summary, the scope of work with JFSB includes addressing issues related to a missed diagnosis or misdiagnosis, DSM-5 challenges, public safety, and the ethics of examiner competence. Collectively, these JFSB circumstances reinforce the need for an expanded diagnostic framework like the DSM-5 Quadrant (Johnson, 2014; Morey, Skodol, & Oldham, 2014; Young, 2013). This paper asserts that the desired diagnostic precision with the DSM-5 requires rethinking with respect to its application with JFSBs. The paper attempts to explicate several JFSB diagnostic issues by adding an alternative method for approaching diagnosis. The central thesis is that an expansion of the diagnostic framework via the DSM-5 Quadrant for JFSB has utility and is a reasonable practice-based progression for the DSM-5. The intent is to expand the diagnostic methods used with this population in a way that positively impacts interventions and other services. The primacy or priority that public safety issues assume in conjunction with the JFSB problem is also stressed. An empirically based rationale for the DSM-5 Quadrant is highlighted, as well as implications for clinical forensic practice, research, training, and supervision.

AN EVIDENCE-BASED PRACTICE RATIONALE FOR CONSIDERING SYMPTOMS OF THE DSM-5 QUADRANT

The use of the DSM-5 Quadrant is consistent with evidence-based practice (EBPP) as EBPP was described by the American Psychological Association Presidential Task Force on Evidence-Based Practice (EBPP, 2006). The task force referred to evidence-based practice as an approach to psychological assessment and intervention that takes under advisement various forms of research. Although much research lies ahead, the crafting of the framework for the DSM-5 Quadrant relied on the DSM-5 revision research process for the mental disorders included in it. In other words, the DSM-5 Quadrant criteria remain faithful to the research core of 12 year-long revisions processed for the DSM-5. Only the DSM-5 symptom criteria are used in the DSM-5 Quadrant. For JFSB, the DSM-5 Quadrant also takes into account the emerging DSM-5 research (APA, 2013). It must be emphasized that the four DSM-5 Quadrant comorbid psychiatric disorders reflect empirically defined and clinically distinct conditions that are in accordance with the DSM-5. According to the DSM-5, “these criteria have been subjected to scientific review” and are based on current research (APA, 2013, p. 10). One component of EBPP is the emphasis on research data to support diagnostic decision making with respect to JFSB. The present DSM-5 Quadrant argument is for additional criterion for evidence when offering diagnostic impressions for JFSB.

Fire setting has been observed in youth with diagnoses such as conduct disorder and oppositional defiant disorder (MacKay et al., 2006). There are other psychological variables operating at the same time, which impact how JFSB symptomatology would present itself in clinical forensic settings. In fact, there are empirical findings that evidence the host of child (e.g., sex, medical status, intellectual), family (e.g., parent psychopathology, family functioning, socioeconomic disadvantage), and community setting (e.g., school and neighborhood disadvantage) factors that correlate with child psychopathology (e.g., Sanders, Szymanski, & Fiori, 2014; Verhulst, 1995).

Historically, developmental psychology has stressed a practice that emphasizes a blend of diagnostically relevant symptom factors. The DSM-5 is organized on developmental and life span considerations, to “assist in diagnostic decision making” (APA, 2013, p. 13). In this case, it appears that psychopathology is often more accurately defined through a mixture or a hybrid of continuous dimensional and discrete elements. Consistent with this approach, the DSM-5 was crafted to offer “more flexible diagnostic concepts for the next epoch of research and to serve as a useful guide to clinicians in explaining to patients why they might receive multiple diagnoses or why they might have received additional or altered diagnoses over their lifespan” (APA, 2013, p. 13). The DSM-5 Quadrant is a hybrid of continuous dimensional and discrete factors that was developed to improve clinical forensic utility with JFSB.

As a diagnostic paradigm, the DSM-5 Quadrant not only has intuitive appeal and is theoretically plausible, but more importantly, it has support from the extant research literature. Clinical forensic research and practice with JFSB reinforce a belief that at least four primary and overlapping symptoms associated with DSM-5 mental disorders are potentially operating. The empirical basis that supports the diagnostic decision-making structure of the DSM-5 Quadrant is reinforced by the DSM-5 (Johnson et al., 2013b; Johnson & Jones, 2014). The DSM-5 Quadrant consists of symptoms found in ADHD, ASD, posttraumatic stress disorder (PTSD), and conduct disorder (CD).

Attention Deficit Hyperactivity Disorder

ADHD is one of the most prevalent neuropsychiatric disorders of childhood with a reported global prevalence rate of 8%–12% (APA, 2013). According to Bilgiç and colleagues (2013) and Jarrett and Ollendick (2008), ADHD is comorbid with anxiety and conduct disorders. Several other researchers report similar findings (Barkley, 2006; Biederman & Faraone, 2005). A diagnosis of ADHD does not carry with it the expectation that a youth would be a JFSB; however, those youth referred for JFSB share some ADHD symptoms. The clinical course of both ADHD and the DSM-5 Quadrant include curiosity about fire or fire interest (Kolko, Herschell, & Scharf, 2006; Kolko & Kazdin, 1991b; MacKay et al., 2006), a history of fire setting (Kennedy, Vale, Khan, & McAnaney, 2006), social skills deficits (Sakheim & Osborn, 1999), peer rejection and interpersonal problems (McCarty & McMahon, 2005), lack of empathy and remorse (Sakheim & Osborn, 1999), and impulsivity (Kolko & Kazdin, 1991a; Sakheim & Osborn, 1999).

Conduct Disorder

According to the DSM-5, CD is comorbid with ADHD as well as anxiety disorders, and this clinical presentation points to a more problematic outcome (APA, 2013). To illustrate, CD is the most prevalent diagnosis in children and adolescents who engage in fire setting (Barnett & Spitzer, 1994; Kazdin & Kolko, 1986; Kuhnley, Hendren, & Quinlan 1982). Clinical samples of juvenile fire setters suggest they are more likely to meet criteria for CD than they are any other major mental health disorder. Included in the 15-symptom diagnostic criteria for CD found in the DSM-5 is fire setting. In terms of the DSM-5 Quadrant, it was found that comorbidity among fire setters, as opposed to non–fire setters, includes depression, oppositional defiant disorder (ODD), and ADHD (Becker, Luebbe, Stoppelbein, Greening, & Fite, 2012,)

Posttraumatic Stress Disorder

PTSD is listed under a new category in the DSM-5: “Trauma & Stress-Related Disorders” (APA, 2013). Research demonstrates that PTSD is a complex and sometimes chronic disorder found in several mental disorders (Brewin, Dalgleish, & Joseph, 1996; Galatzer-Levy, Nickerson, Litz, & Marmar, 2012). A strong relationship between ADHD and PTSD has been well represented in the literature (Adler et al., 2013; Gurvits et al., 2000). In relation to the DSM-5 Quadrant symptoms, Biderman et al. (2013) found that a comorbid condition of ADHD and PTSD often coincided with increased risk for other mental health comorbidity as well as psychosocial impairment. In fact, according to Cruise and Ford (2011), youth involved in the juvenile justice system (e.g., JFSB) can present an array of symptoms that are a result of cumulative exposure to traumatic events and struggle with impairments that are reflected in poor self-regulation (e.g., fire-setting or bomb-making behaviors). In fact, the prevalence of PTSD in juvenile justice samples is comparatively high when contrasted with youth found in community settings.

Autism Spectrum Disorder

It has been reported that as high as 70% of individuals with ASD have some comorbidity with other mental health symptom complaints (Einfeld, Tonge, & Clark, 2013). For example, social skill deficits found in ASD can be a factor in fire-setting behavior (Radley & Shaherbano, 2011). An assessment of ASD sometimes requires going beyond the standard guidance offered by the DSM (Baio, 2008; Bauman, 2010; Coury, 2010; Kohane, 2012; Xue, Brimacombe, Chaaban, Zimmerman-Bier, & Wagner, 2008; Smith, 1981). In terms of the DSM-5 Quadrant, ADHD seems to be the most commonly reported comorbid disorder in children diagnosed with ASD. According to Antshel et al. (2013) and Schneider, Gadow, Crowell, and Sprafkin (2009), ADHD and ASD are common psychiatric comorbidities for each other. Other authors reported similar connections between ADHD and ASD as well (Leyfer et al., 2006; Matson & Cervantes, 2014). The weight of the aforementioned summarized research provides specific empirical support for the rationale of the relationship identified between JFSB and the diagnostic symptoms that comprise the DSM-5 Quadrant.

THE DSM-5 QUADRANT IN CLINICAL FORENSIC PRACTICE

Psychologists frequently have to take on various professional roles as they work with JFSB. The interdisciplinary work that often occurs with JFSBs by default means that formulating a diagnostic impression is achieved by the integrated information provided by a team (e.g., attorneys, mental health counselors, psychologists, social workers, and public safety personnel). Clinical forensic psychological practice relies on the ability of an examiner to craft a clinically relevant picture of a set of symptoms associated with JFSB. This process also allows one to make various decisions about how the case should be managed (i.e., clinically and from a public safety standpoint). JFSB is not a diagnosable mental disorder; however, collecting culturally relevant data on JFSB can enhance the precision of the diagnostic process. The use of the DSM-5 Quadrant requires that at a minimum the forensic psychological examiner collect all medical records, previous psychological reports, legal records, mental health treatment notes, and school records, which in totality creates what appears to be a considerable amount of information that serves as the fuel for the first step in the diagnostic process (Johnson & Jones, 2014).

The DSM-5 Quadrant has four wireframes of symptoms associated with DSM-5 disorders (i.e., ADHD, ASDM CD/ODD, and PTSD; Johnson, 2014; see Figure 1). In terms of an overview, the symptoms found in the DSM-5 Quadrant fall along a frequency index (diagnostic line) starting from the left (lower) to right (higher). As the examiner determines the presence of various symptoms, they are marked along the diagnostic line for the specific

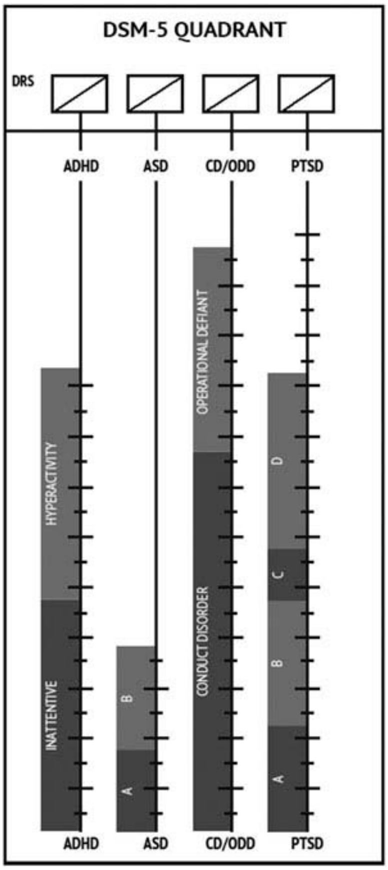

FIGURE 1 DSM-5 Quadrant.

DSM-5 disorder. It is recommended that the examiner start the process by selecting the disorder believed to have the most symptoms. This process is repeated until all four of the DSM-5 Quadrant wireframes are completed. The examiner makes a clinical decision (e.g., based on data) of where to start based on his or her judgment as to which collection of symptoms (i.e., highest number) are believed to best fit within those from the first frame selected in the DSM-5 Quadrant.

In practice, there are five steps in using the DSM-5 Quadrant. The first step in the diagnostic process of the referred JFSB involves following the guidance provided by the DSM-5 (APA, 2013). This step involves assessing for the possible presence of two or more disorders relevant to DSM-5 or ICD-Z Codes as appropriate (Saxena, Esparza, Regier, Saraceno, & Sartorius, 2012). After the examiner has completed the information gathering, the DSM-5 Quadrant holds that five core steps are involved in crafting a diagnosis with JFSB. The examiner marks (x) on the DSM-5 Quadrant Profile Sheet where he or she believes the patient's symptoms match up. Each tick mark in the profile sheet represents the presence of a symptom. A diagnostic wireframe is a line where tick marks are used to designate all the symptoms associated with a specific mental disorder. For example, after assessing a patient for the ADHD wireframe, the examiner may then determine that the JFSB has three of the symptoms. Starting from the left of the profile sheet, the examiner would go over three tick marks and then place a mark (x) on the third one (i.e., the respective DSM-5 symptom). This same process is followed for each wireframe of the DSM-5 Quadrant.

Dimensional Ratings of Symptoms

In accordance with the DSM-5, a dimensional approach can promote research across diagnostic categories that are expected to function as an advancement over strictly categorical methods (APA, 2013). The practice benefits of a dimensional assessment of psychopathology are accrued through a metric that indicates the severity of symptoms similar to those found in the DSM-5 Quadrant. The Dimensional Ratings of Symptoms (DRS) recognizes the multiple degrees of the symptoms assessed in the DSM-5 Quadrant (Kessler, 2002; Krueger, Watson, & Barlow, 2005). The DRS was crafted to be a brief, easy, and reliable measure that integrates two function ratings for the different symptoms of a JFSB. The DRS compliments and extends the diagnostic information of a categorical approach by adding a dimensional assessment that is consistent with the DSM-5 (APA, 2013). In this case, there is further clarification of the symptoms comprising the comorbidity found in DSM-5 Quadrant (Kraemer, 2007; Skodol & Bender, 2009). From a clinical forensic applicability perspective, at the end of each diagnostic wireframe is a function box that is divided diagonally (see Figure 1). The top half of the function box is where a licensed and qualified mental health examiner enters an assessment (e.g., others = O, self = S, or both = +) based on how the symptoms of a specific disorder are determined to be impacting the JFSB. Functioning on the top side of the box refers to the extent the symptoms are impacting the level of impairment with self, others, or both. Right next to this assessment (i.e., others, self, or both), the examiner uses a numerical scale that includes 0 for low, 1 for medium, 2 for high, and 3 for extreme to designate the collective impact or strength of the symptoms on the JSFB functioning. That is, the impairments are described with respect to other or self and impairments that range from low to extreme. An examiner relies on information collected during the data gathering to determine where (others, self, or both) the quadrant symptoms are most negatively impacting a JFSB, as well as to what extent (low to extreme).

Historically, there are several examples of functional assessment that have been used (e.g., GAF, GAS, SFS, SOFAS, DASII) and, more recently, the DSM-5 has included the World Health Organization Disability Assessment

Schedule 2.0 (WHODAS; APA, 2013). The functional assessment used in the DSM-5 Quadrant is reflective of how a JFSB operates in relation to others or self. The lower side of the diagonal function box is used to designate the level of *pervasiveness* of the symptoms (low = L, medium = M, high = H or Extreme E). The *pervasiveness* is generally described as the prevalence of the symptoms in various settings (e.g., community, home, school, or work).

When it comes to clinical forensic practice, the DSM-5 Quadrant offers relevant explanatory power that is important, but circumscribed to the viewpoint of JFSB clinical forensic practice. In this respect, the DSM-5 Quadrant is more of a diagnostic decision aide and a graphically based communication tool. There is an increase in the clinical utility of the DSM-5 Quadrant because of its ability to provide information about a more comprehensive diagnostic status that is critical for other public safety intervention variables. Thus, the DSM-5 Quadrant requires the continuous accumulation of data (Johnson, 2014). The practical application of the DSM-5 Quadrant in the diagnostic process is noted by its function as a method for understanding a JFSB through using clinical forensic information (i.e., interviewing, psychological testing, review of records, conversations with collaterals). Thereby, the DSM-5 Quadrant promotes informed decision making and ostensibly functions as a diagnostic communication approach.

IMPLICATIONS FOR CLINICAL FORENSIC PRACTICE, RESEARCH, TRAINING, AND SUPERVISION

Additional testing of the DSM-5 Quadrant is required. What is empirically supported is the nexus between each of the disorders (i.e., ADHD, CD, ASD, & PTSD) identified in the DSM-5 Quadrant for JFSB. Understanding the role of the DSM-5 Quadrant fuels the examination of an option that moves toward an operational framework that is expected to impact research, training, and supervision practices. For example, the ethnoracial and behavioral manifestations of JFSB involve more than just the one diagnostic domain. Some might even argue that the DSM-5 diagnostic categories restrict how an examiner conceptualizes and assesses clinical forensic problems like JFSB (Goldfried & Wolfe, 1998; Persons & Silberschatz, 1998; Silverman, 1996). Varied clinical presentations combine with a range of examiner competencies to further complicate decision making and of course may lead to inaccurate psychiatric diagnoses for JFSB. The DSM-5 Quadrant addresses this problem by providing the scaffolding for additional research and supervision related to the decision making required to reduce some of the complexities involved in the forensic evaluations of JFSB (Johnson, 2014). From a supervision perspective, the JFSB diagnostic issues can contribute to inappropriate interventions and increased public safety risks. The DSM-5 Quadrant increases reliability and validity of the diagnostic approach because it identifies the many contours of the JFSB symptom patterns. From a research standpoint, a longitudinal study that includes a statistical accounting of the DSM-5 Quadrant symptoms offers a standard methodology that when attached to a relevant history could assist in uncovering some of the underlying etiologies associated with JFSB.

With the numerous implications of diagnostic practices for intervention, and public safety policy, this topic is deserving of additional research attention. There are three ways that this article contributes to subsequent forensic psychological JFSB research, training, and supervision stemming from the use of the DSM-5 Quadrant. First, the article reflects an empirically supported theoretical framework for understanding the DSM-5 symptom patterns with respect to JFSB. Second, the article extends thinking by examining the collective relationship of diagnostic symptoms and how they interrelate in JFSB cases. It is projected that additional ethnoracial DSM-5 research findings will continue to demonstrate symptom pattern data that is specific to the differences already found in the histories of individuals diagnosed with various disorders (Freeman, Cronin, & Candela, 2002; Johnson, 2013c). Third, following the guidance offered in this article can offset the existing research shortage at least partially. Taken as a whole, the forensic psychology practice field (e.g., distinguishing comorbid JFSB symptom patterns) is advanced by the analytical discussion of this area. While the JFSB symptoms may not always meet the threshold specific to a particular DSM-5 disorder, there is no denying that the diagnostic information yielded from the DSM-5 Quadrant is expected to influence supervision and training.

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